



Illinois HIV Planning Group (ILHPG)

August 19, 2016, 10:00 am-12:30 pm Meeting - Minutes

- Welcome; introduce co-chairs, facilitator and presenters; and acknowledge moment of silence (5 minutes)
The Co-Chair welcomed everyone to the meetings and reminded members of the purpose of the ILHPG and its work. She thanked everyone for their help and participation in the development of the Integrated Plan, which the Illinois HIV Integrated Planning Group concurred with at its last meeting. It has been sent to IDPH Communications for approval. ILHPG Co-chairs, meeting facilitator, and presenters were introduced. The Co-chair led the group in a moment of silence.
- Review formally adopted agenda-
The agenda for the meeting, which was formally approved by voting members of the group in advance of the meeting, was reviewed.
- Webinar process; Attendance/Roll call; Announcements (15 minutes)
 - Webinar meeting, online meeting survey, and online discussion board instructions - *Participants were provided webinar instructions and informed of where and how to locate all meeting documents and resources.*
 - Announce logged in members and take roll call of other voting members to verify quorum- *Roll call was taken and announced.*
 - ILHPG Leadership- *Leadership was introduced and acknowledged.*
 - Voting protocol- *The voting protocol was made available to participants but was not reviewed as there was not a vote scheduled for this meeting.*
 - Announcements
 - » 2016 Cumulative voting and non-voting member meeting attendance log- *Members were asked to review updated ILHPG meeting and committee attendance logs that will be sent out after the meeting.*
 - » Reminder: 2017 New Member recruitment – applications are due to Janet or Marleigh by September 16, 2016 –*Applications and the cover letter are available at ilhpg.org/apply. Members were encouraged to share the application with interested candidates.*
 - » Reminder: Upcoming October 25, 2016 Integrated Planning meeting- *Members were reminded that the next ILHPG and Integrated meetings will be held face-to-face in Springfield in conjunction with the HIV/STD Conference. The ILHPG will have a short business meeting from 8-9:15am, and the Integrated Planning Group will meet from 9:30am- 12pm. Lodging for voting members will be covered by the ILHPG. There is no conference registration fee this year. More details will be forthcoming.*
 - » Posted Reports/Updates:
 - Committee, Liaison and Regional Lead Agent, RIG Rep, and IDPH HIV Section reports- *The Co-chair reminded members that all reports are available at ilhpg.org/webinar.*

- » Review meeting objectives and Concurrence checklist – *Meeting objectives were reviewed by the Community Co-chair. The Concurrence checklist was provided to participants but not reviewed as the 2016 concurrence process was completed at the last Integrated Planning Meeting.*
 - Present and Discuss Results of FY2015 Ryan White Part B Client Satisfaction Surveys (40 minutes)

LaDaryl Hale, IDPH Ryan White Part B Linkage to Care Coordinator

LaDaryl provided a comprehensive overview of the results of the FY15 Ryan White Part B Client Satisfaction Survey. He informed the group that this survey is used to identify gaps in services for RWPB clients and that this year's survey included new questions about PrEP. Approximately 5,000 surveys were mailed to clients, and 1,000 were returned. This year's survey had a drop in responses compared to previous years due to an earlier response deadline so that the results could be included in the Integrated Plan. LaDaryl reviewed the demographics of the participants by gender, age, race/ethnicity, time of initial diagnosis, current risk factor, time since last visit to a physician for HIV care, current living situation, and region.

LaDaryl continued by reviewing the results of questions about RWPB core services. He reminded everyone that the core service questions are on a two year survey rotation, so not all core services were addressed in this survey. This year, clients were asked about services provided by medical case managers, HIV medical providers, ADAP staff/ pharmacy services, and dental providers. Overall, all core service categories received high satisfaction rates (>95%) in regards to friendliness and confidentiality of providers. Results of questions about supportive services were also reviewed. Like core service, support service questions are also on a two year rotation. This year, clients were asked about food/meal assistance, housing services, utility assistance, and legal services. Overall, all supportive service categories received high satisfaction rates (>90%) in regards to friendliness and confidentiality of providers.

LaDaryl then reviewed the results of questions asked about PrEP and prevention. Of respondents, 45.8% had never heard of PrEP, 36.6% had some knowledge of PrEP, and 17.6% had extensive knowledge of PrEP. Additionally, 26.9% of respondents and/or their partners were interested in learning more about PrEP. Other questions about prevention topic (like partner notification, access to free condoms and syringes, HIV testing, and medication adherence) were also included in the survey. Clients were also asked if they needed additional assistance or information about other services such as housing, partner or family violence, harm reduction, health insurance enrollment, substance abuse services, mental health services. All results are included in LaDaryl's slides.
 - Input, Questions, Follow-up (10 minutes)
 - Comment: *Clients may already know about PrEP and may be why they respond "no" to needing more information.*
 - Answer: *That may be the case, but there is also a large population who had not heard of PrEP (46%). Reasons can vary from person to person.*
 - Question: *It was noted that 15% of respondents reported having "no case manager." Is case management required to access Ryan White services?*
 - Answer: *If a client is only using ADAP or PAP, they are not required to utilize case management if they are self-sufficient.*
 - Question: *It was noted that 58% of clients reported knowledge of Partner Services. Are Case Managers conducting Partner Services every six months at recertification in each region?*
 - Answer: *Yes, this is a part of the eligibility assessment.*
 - Question: *How representative were the respondents of the people seen in case management? For example, there were a very low number of respondents in the youth age group. Does the proportion of those respondents actually reflect the clients in case management?*

- Answer: *The proportion of respondents among age groups is not reflective of proportions of clients actually served. This data is self-reported, and surveys seem to be turned in more by older adults. Hopefully in the future, more surveys will be turned in and more youth will be included.*
 - Question: *How many surveys were distributed?*
 - Answer: *About 5000 were distributed.*
 - Question: *It was noted that 58% of clients reported being offered STI screening. Are there plans to increase and offer STI screenings as a part of case management?*
 - Answer: *STI screening is always offered. The contradiction in reporting may be due to how clients are responding/ reporting. Sometimes clients leave items blank or do not respond accurately if they fear that someone will be able to identify them with this information, so getting good data can be difficult.*
 - Question: *Since changing the format of the survey and making it shorter by doing two year rotations, have you received a greater response rate?*
 - Answer: *There has been about a 10% increase in responses with the smaller survey.*
- Hepatitis C Prevention and Treatment – (40 mins) with 10 mins discussion Brief break (5 minutes)
Lesli Choat, IDPH STD and Viral Hepatitis Coordinator
Lesli began by giving an overview of Hepatitis C trends in the United States. She reported at it is estimated that 3.2 million people in the US have chronic HCV, but an estimated 75% are undiagnosed. Populations most at risk are people born 1945-1965, MSM (both HIV- and HIV+), and injection drug users. From 2010-2013, HCV cases in the US have increased by 151%. Lesli explained that people living with HIV and young injection drug users in suburban and rural areas are disproportionately affected by HCV. Among all PLWH in the US, it is estimated that 25% are co-infected with HCV. Among PLWH who inject drugs, it is estimated that 80% are co-infected with HCV. Lesli also reviewed the CDC's HIV/HCV vulnerability assessment of the United States. This assessment identifies US counties that are at high risk for an HIV/HCV outbreak similar to the Indiana outbreak upon the introduction of HIV/HCV into PWID communities.
Lesli then discussed HCV prevention. She stated that the main HCV prevention strategies included syringe access and education, opioid substitution therapy (OST), and treatment as prevention. Unfortunately, syringe access and education, OST services, and treatment are scarce or inaccessible to populations in need. Lesli reviewed the national HCV Care Continuum and explained some of the barriers to HCV care, which include delays in treatment due to spontaneous clearing, restrictive guidelines for insurance coverage (scoring requirements), and length of treatment.
Lesli then presented an overview of Illinois HCV data. This data is collected through INEDSS but should be interpreted with caution. Some data is incomplete, and electronic reporting only accounts for positive data. Negative testing data is not included. Lesli explained that almost all HCV infections reported to IDPH are chronic (as opposed to acute). She also reviewed the demographic distribution of HCV in Illinois by age, gender, race/ethnicity, and county. She also reviewed a map that identified which Illinois counties had the highest rates of reported HIV in 2015. All demographic distribution information and the HCV rate by county map are included in the slide set.
Lesli informed the group of HCV related programs that have been conducted in Illinois. In 2013, the Illinois Hepatitis C Task Force was created and has worked to create advocacy and legislation in support of HCV prevention and treatment. They collaborated with the Illinois State Medical Society (ISMS) to bring HCV education to providers. The Hepatitis C Community Alliance to Test and Treat (HEPCCATT) is a direct CDC grant implemented in Chicago for HIV testing, linkage, and treatment. In 2015, the STD and HIV sections at IDPH collaborated to create to conduct HCV screening of the birth cohort to local health departments. The project soon began to offer HCV testing to IDU and anyone who could benefit from knowing their status and is still continuing. Rapid tests are supplied to 15 sites in Illinois, and HAV and HBV vaccinations are also available at the sites. Anyone who has a positive test is given educational materials and referred for further testing. Overall, this project has had a 4.4% positivity rate. HCV testing is also being performed in jails, as

part of PCSI screening, and at Summit of Hope events. Lesli also mentioned that additional funding for HCV rapid test kits are available through Orasure. Please contact Lesli for details.

– Input, Questions, Follow-up (10 minutes)

- Question: *Is the huge increase in HCV incidence (151%) attributable to increased screening? Is there any way to assess how many of these new diagnoses were actually infected many years ago?*
- Answer: *There is really not a good way to tell when someone was infected. There has been an assumed increase in screening, but we do not have good data. Positive HCV tests are reported to IDPH, but the number of negative tests is not reported. This makes measuring screening efforts difficult.*
- Question: *Was the purpose of the HIV/HCV vulnerability assessment to identify counties in which HIV/ HCV could spread rapidly if introduced or where HCV is already spreading rapidly?*
- Answer: *The purpose of the assessment was to create awareness so that communities that could be at risk of an outbreak similar to that in Indiana were identified. The assessment does not identify where outbreaks are certain to occur but could occur if HIV/HCV were introduced into the PWID community.*
- Comment: *Great presentation; very comprehensive and understandable!*
- Question: *Is annual HBV testing for MSM recommended even if MSM have been vaccinated?*
- Answer: *Although I am not certain, I would assume that testing is not recommended if the individual has been vaccinated. HBV testing is complicated, so it would be difficult to determine if a positive test is due vaccination or new infection in vaccinated populations. In this case, I think that immunity among vaccinated individuals could be assumed. There is no HCV vaccine, but HCV testing is more straight forward. Once exposed, however, antibody testing will always be positive, so more testing is needed to determine if the virus is still active in the body.*
- Question: *What is being done to train providers on weaning prescription opioid abusers off the drugs before becoming an injector?*
- Answer: *The Illinois State Medical Society recognizes that there is an overuse of prescription opioids. Although I am not certain on the specifics of education for providers on these issues, it is assumed that some education is going on. Work is being done to identify injectors and to get them OST. Nationally, additional work still needs to be done to strategize on how to address HCV-related issues. Lake County has a great comprehensive program called A Way Out Lake County that can be modeled throughout the state. Law enforcement officers in Lake County are trained with Narcan and Naloxone and have saved over 60 lives. Another component of the program is that PWID can go to one of five designated police stations in Lake County to turn in their drugs and equipment. They are not charged for their possession and are immediately taken to a treatment facility. Any person can utilize this service; it is not limited to Lake County residents only.*
- Comment/ Question: *Great presentation! What recommendations do you have for those conducting HIV CTR to better screen for those most at risk for HCV?*
- Answer: *Anyone who feels that they could benefit from an HCV test is a candidate as HCV can be transmitted through blood or seminal fluid. It is good to recommend/offer testing to people belonging to at-risk populations so that they can know their status and be referred on to further testing if needed.*
- Question/ Comment: *Has the HCV Task Force done any advocacy about the barriers that federal regulations place on Methadone & Buprenorphine? Suppressing community HIV viral loads would never happen if HIV+ persons had to get their antiretroviral medication at a clinic every morning before work---but that's what we expect Methadone patients to do. Same with the limitations on the number of patients for whom one doctor can prescribe Buprenorphine. Could the task force generate advocacy letters to the FDA (or appropriate agencies) about eliminating these barriers to needed opiate-treatment medications?*

- Answer: *This issue has not been addressed by the Task Force as this is more of an Opioid Crisis Task Force Issue. They may be working to address on something to address this. The primary goals of the HCV Task Force are to increase HIV screening and access to care and to spread the word about HCV through personal stories of infected or affected individuals.*
- Question: *Do you think that cost and barriers to treatment play a part in not making screening mandatory?*
- Answer: *I don't think that cost is a barrier to testing as it is quite inexpensive. A significant barrier to testing is that medical providers do not want to be mandated to perform HIV testing, so education is needed to be sure that providers understand who to test and why it is important. Now that new treatments exist, any physician or physician assistant can case manage an HCV patient, but more training among providers is needed. Cost can be a barrier to treatment. Very few people are approved for treatment, even if they have insurance. HCV is one of the only diseases where people are told that they are not "sick enough" to receive treatment because of scoring restrictions. In the future, hopefully more dollars can be allocated to HCV programs. Strategies are in place, but necessary funding to conduct programs are not available.*
- Question: *Are there medication assistance programs available?*
- Answer: *Yes, several pharmaceutical companies offer assistance programs.*
- Comment: *The Ryan White ADAP Program is conducting a pilot project to supply HCV medication assistance for individuals with HIV/HCV co-infections. Approximately 80 seats are still available. Initially, the scoring criteria was F2 or higher, but the program has recently changed that qualification to an F1 score or higher. The initial requirement of the provider to prove denial of treatment from Medicaid or another third party payer source has also been waived.*
- Question: *Some state jurisdictions have priority admission for those living with HIV/HCV who are seeking substance abuse treatment. Is this something that providers are doing/can do here in Illinois?*
- Answer: *I am not aware, but this sounds like a great idea.*
- Public Comment Period/Parking Lot (10 minutes)- *No public comment requests were received. There were no items in the parking lot.*
- Adjourn- *The meeting formally adjourned at 12:10pm.*